CHAPTER II: PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION FACILITIES ASSESSING THE MEDICARE PATIENT

OBJECTIVE

The following chapter provides participants with key patient assessment process information related to the prospective payment system for inpatient hospital services provided by a rehabilitation hospital, or rehabilitation unit of a hospital. The new assessment process and schedule of completion requirements are reviewed.

ASSESSING THE MEDICARE PATIENT

Patient Assessments

- **Required for New Admissions on or after January 1, 2002**
- **Required on Current Inpatients**
- **Performed by a Clinician**

The Inpatient Rehabilitation Facility (IRF) Final Rule of August 7, 2001, required the implementation of a patient assessment instrument (PAI) to be performed at designated intervals.

Beginning January 1, 2002, in accordance with the IRF Final Rule a **clinician** must perform a comprehensive patient assessment using the IRF PAI on all Medicare Part A fee-for-service patients.

The assessments must be performed on beneficiaries already inpatients of the IRF as of January 1, 2002, and new admissions on or after January 1, 2002, regardless of the IRFs cost reporting start date.

Clinician is Defined as:

- **An IRF Employee**
- **Employee Contracted by the IRF**
- **Trained in the Performance and Completion of the PAI**
- **More Than One Clinician May Be Involved**

A **clinician** is defined as either an employee of the IRF or an employee contracted by the IRF who has been trained in how to perform a patient assessment using the IRF PAI. More than one clinician may be involved in the assessment completion. For example: In the case of some neuromuscular items the experience and specialized training of a physical or occupational therapist may be beneficial to obtain the most accurate information. The objective of the IRF assessment process is that the data collected is representative of the patient's circumstances and clinical status.

THE ASSESSMENT PROCESS AND THE RIGHTS OF THE PATIENT

The Rights of the Patient

- **Must Be Informed of Their Rights Prior to Assessment**
- **Clinician Must Document That The Patient Has Been Informed in the Clinical Record**

In order for the IRF to receive Medicare payment for services furnished, a clinician must inform Medicare inpatients of their rights before an assessment is begun. The IRF must ensure that a clinician documents in the patients' clinical records that the patients have been informed of their rights. The IRF should note that the patient rights listed below are in addition to those specified under the conditions of participation for hospitals in 42 CFR 482.13.

The patient has the following rights.

- Be informed of the purpose of the assessment data collection
- Have any information collected remain confidential and secure
- Be informed that the information will not be disclosed to others except for purposes allowed by Privacy Act and federal or state regulations
- Refuse to answer patient assessment data questions
- See, review and request changes on the patient assessment instrument.

PATIENT REFUSALS

Patient Refusals

- **If the Patient Refuses to Answer, Information May Be Obtained From Other Sources**
- **Clinician May Use Discretion to Document in the Clinical Record the Source of Information**

If a patient refuses to answer questions during the assessment process, the information may be obtained from the following sources:

- Patient's clinical record
- Other patient documents
- Patient's family
- Another person personally knowledgeable about the patient's clinical condition or capabilities.

The information obtained from the above sources does not have to be specifically noted on the paper or electronic version of the PAI. The clinician has the discretion to note in the patient's clinical record that the information recorded was obtained from one of the sources indicated above and not directly from the patient.

ASSESSMENT TERMINOLOGY

Assessment Terminology

- **Terms Defining the Various Dates in Which Information is Gathered, Entered and or Transmitted**
- **Terms**
  ARD
  Completion
  Encoding
  Locked
  Transmitted

The assessment process is comprised of various dates in which information is gathered, entered and or transmitted to a CMS designated database. The following terminology is used to designate all required assessment functions and or processes:

Assessment Reference Date or "ARD"

This is the last day of the assessment observation period

Completion Date

This is the date the PAI must be completed

Encoded Date

This is the date in which the PAI assessment items must be entered into the software that is the computerized version of the IRF PAI

Locked Date

The date the assessment data has successfully passed the CMS database system edits

Transmission Date

The date by which the assessment data must be transmitted.

ASSESSMENT DOCUMENTATION REQUIREMENTS

Assessment Documentation

- **Critical to the Accurate Placement and Proper Billing**
- **Must be Documented to Establish the Medical Necessity of the Services Rendered**
- **Clinical Status Must be Verifiable and Consistent With the Clinical Record**

An accurate recording of the data on the PAI by the IRF staff is critical to the proper placement of the patient and payment of the claims submitted by the IRF. The information may also be used to refine IRF PPS requirements and future payment.

One principle governing appropriate Medicare payment and utilization of services is that there be documentation establishing that the services furnished to inpatients must meet the requirements set forth in section 1862 (a) of the Act.

When the data on the assessment accurately reflects the patient's clinical status, they form the basis for documenting whether or not the services furnished by the IRF to the patient were medically reasonable and necessary.

The patient's clinical status for a given time period must be verifiable and consistent with the clinical information independently or separately recorded in the patient's clinical record.

Additional forms of documentation that will support the accuracy of the recorded information and the medical necessity of the furnished services must be recorded in the patient's medical record and could include, but is not limited to:

- Physician's orders
- Physician notes
- Nursing notes
- Notes from therapists
- Diagnostic tests and results
- Other associated information, such as social worker or case manager notes

COMPLETION OF THE PATIENT ASSESSMENT INSTRUMENT

The Patient Assessment Instrument

- **Composed of Data Elements to Collect Clinical Information**
- **The Observation Period is Generally 3 Days Unless Otherwise Specified**
- **User Guide Will be Available From CMS**

The IRF PAI is a modified version of the UDSmr patient assessment instrument. The IRF PAI is comprised of nine sections of data with some of the sections used to collect information on the patient's clinical condition. Each data element has a defined observation period in which to capture the clinical information. In general the assessment time frame for all patient assessment instrument items is three calendar days.

The CMS IRF PAI guide will provide detailed guidelines on the optimal time frames to observe the patient. The guide will be provided to the IRF.

EXTENDED ASSESSMENT OBSERVATION TIME FRAMES

Extended Assessment Time frames

- **Additional Time to Capture Patient Information**
- **Information May be Obtained from Other Sources**
- **The Admission Assessment Reference Date (ARD) Remains Day 3**

There are circumstances when it may be necessary to allow additional time to appropriately capture clinical information. The information obtained allows for the monitoring of quality of care and payment objectives of the instrument to be met.

If additional assessment time is required, the IRF may obtain information from other sources to assess the patient's clinical condition for the time period prior to the patient's current IRF hospitalization.

The sources may include but are not limited to:

- Patient's physician
- Clinical record from the immediately preceding acute care hospital stay
- Medical records maintained by an HHA if the patient was being furnished services by the HHA immediately prior to the IRF stay.
- Information from the patient's family or someone with personal knowledge of the patient's clinical condition.

In the case of extended observation periods, the ARD would remain at Day 3. In this period the IRF would assess the data item using data collected during the first three days of the patients current IRF Hospitalization. In addition, other calendar days as defined by the data element would be used to obtain data from the previously identified sources.

REQUIRED ASSESSMENTS

Required Assessments

- **Admission to the IRF**
- **At the Time of Discharge From the IRF or When Medicare Part A Fee for Service Services Cease**

The IRF final rule requires completion of two assessments, one upon admission to the IRF and the second at the time of discharge from the IRF, including upon the death of the patient and or cessation of Medicare Part A fee-for-service covered services.

Admission Assessment

Admission Assessments

- **Provide the Basis for CMG Assignment**
- **Patient Observation Occurs During the First Three Days of the Stay**

The admission assessment provides the basis for the assignment of a specific CMG for each patient. The clinical staff will observe and assess the patient during the first three days of the patient's covered Medicare Part A fee for service stay.

The applicable timeframes are as follows:

- **Observation Period** = Days 1-3
- **ARD** = Day 3
- **Completion Date** = Day 4
- **Encoded Date** = Day 10
- **Transmission Date** = This is the date applicable to the transmission of the discharge assessment

Discharge Assessments

Discharge Assessments

- **Used to Record the Relevant Weighting Factors Associated With Patient Comorbidity**
- **Performed at the Time of Discharge From the Facility**
- **Or When Part A Services Cease**
- **In Most Cases Assessment Time Period will not Include a Calendar Day Prior to or Include the Admission ARD**

The discharge assessment is used to record the relevant weighting factors associated with the patient's comorbidities. The clinical staff will have to observe the patient in between the admission and discharge assessments in order to obtain motor and cognitive data for use during the discharge assessment. The discharge assessment is done on the date the patient:

- Discharges from IRF
  or
- Ceases receiving Medicare Part A fee-for-service covered inpatient rehabilitation services (This includes inpatients that remain inpatient or expire)

The applicable timeframes are as follows:

- **ARD** = The date of discharge or the discontinuation of covered services (This is counted as Day 1.)
- **Completion Date** = Day 5 following discharge or discontinuation of covered services
- **Encoded Date** = Day 7 following the completion date (This is counted from the completion date which represents the first day of the counting sequence, day 1.)
- **Transmission Date** = Day 7 following the encoded date (Encoded date represents the first day in the counting sequence.)

Interrupted Stay

Interrupted Stay

- **A Stay in Which Beneficiary is Discharged and Returns Within 3 Consecutive Calendar Days.**
- **Begins Day of Discharge**
- **Ends on Midnight the Third Day**
- **Deemed a Continuation of the Prior Assessment**
- **One Discharge Assessment at the end of the Stay**

An "interrupted stay" is defined as a stay in which the beneficiary is discharged and returns to the same IRF within three consecutive calendar days. The three calendar days begin with the day of discharge from the IRF and end on midnight of the third day.
If the patient returns by midnight of the third day, the inpatient stay is deemed a continuation of the prior one. In this circumstance it is necessary to make the completion date of the discharge assessment the end of the interrupted stay. If two discharge assessments are done, the initial discharge assessment would cause a rejection of the true discharge assessment when submitted.

Interrupted Stay during an Admission Assessment Period

Interrupted Stay During Admission Assessment Period

- **The Assessment Schedule is Shifted Forward by the Number of Days the Patient was Absent**

If the beneficiary has an interrupted stay where the absence takes place during the three-day initial assessment period, the admission assessment schedule is shifted forward by the number of days the patient was absent. The following schedule dates are impacted by this forward shift:

- ARD
- Completion Date
- Encoded Date

The transmission date is not impacted by this absence since the admission and discharge assessments are transmitted together.

LOCKING AND TRANSMISSION OF THE PAI

Locking and Transmission of the PAI

- **Assessments are Transmitted Using Free Software to a Designated Database**
- **Admission, and Discharge Assessments are Transmitted at the Same Time**
- **Assessment is "Locked" When Data Edits Have Been Successfully Passed**

The IRFs must enter or "encode" the assessment data information into a software program that CMS will supply free. The software program will then assign a CMG based on the IRF PAI data. The program will include the grouper that will assign the CMG.

The admission and discharge assessments are transmitted together to a designated database center.

The admission and discharge assessment data record is considered "locked" when all specified data element edits have been passed and the transmitted data are accepted by the CMS database.

Late Transmission of Assessments

A late transmission is defined as a **transmission more than 10 calendar days late.**

Late Transmissions

- **Defined as a Transmission More Than 10 Days Past the Designated Transmission Time Frames**
- **Penalty Assessed of 25% of the CMG Determined Payment**

Penalty for Late Transmissions

If the PAI is transmitted more than 10 days late, the IRF will be paid a CMG-determined payment that will be reduced by 25 percent.

RECORD KEEPING REQUIREMENTS

The IRF must maintain all completed Medicare patient assessments that were performed using the IRF PAI for the previous five years either in paper or electronic file formats.

Record Keeping

- **Assessments Must be Maintained for 5 Years**
- **Paper or Electronic File Format**

The assessments may be used for the following purposes:

- Retrospective review conducted at the IRF to determine medical necessity of the services rendered
- As part of an investigation by state or federal agencies
- As a back up to the CMS electronic database.

MEDICAL REVIEW UNDER THE IRF PPS

Medical Review

- **Data Analysis May be Conducted to Identify Program Vulnerabilities and**
- **To Ensure That Appropriate Payment is Being Made**

Under a discharge-based prospective payment system, IRFs might have financial incentives to miscode information on the patient assessment instrument in order to gain a higher CMG and, therefore, payment (that is, case-mix upcoding for payment). Data analysis may be conducted to identify program payment vulnerabilities or areas of risk, and medical review may be conducted to ensure that appropriate payment is being made for services furnished by IRFs.

PATIENT ASSESSMENT SCHEDULES AND ASSOCIATED DATES

Chart 1- "Admission Assessment"

Assessment Type	Hospitalization time period and Observation time period	Assessment Reference Date	Completed on Date	Payment Time Frame covered by the assessment	Encoded By Date	Transmitted By Date
Admission Assessment	First 3 days	Day 3 *	Day 4	Entire Medicare Part A Stay period	Day 10	See ** below for how to calculate

* Exception for some items discussed in section IV A.3 of the final rule preamble.

** Because all the assessment data for the admission and discharge assessments must be transmitted together after the patient is discharged or stops receiving Medicare Part A fee-for-service services, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument "encoded by date."

Chart 2- Applying the "Admission Assessment Schedule" and Associated Dates Medicare Part A Stay = 7/3/02-7/16/02

Assessment Type	Hospitalization time period and Observation time period	Assessment Reference Date	Completed On Date	Encoded by Date	Transmitted By Date
Admission Assessment	First 3 days Patient admitted on 7/3/02	7/5/02 *	7/6/02	7/12/02	See ** below for how to calculate

* Exception for some items discussed in section IV A.3 of the final rule preamble.

** If the patient is discharged on 7/16/02, the last permitted discharge patient assessment instrument encoding date is 7/26/02, and the admission and discharge data must be transmitted by 8/01/02. See Chart 3, which illustrates how to apply the patient assessment instrument discharge dates. Note that the span of time to complete the admission assessment is different from the time to complete the discharge assessment as discussed in this section IV.D of the final rule preamble.

Chart 3- Applying the "Discharge Assessment Schedule" and Associated Dates Medicare Part A Stay = 7/3/02-7/16/02

Assessment Type	Discharge Date *	Assessment Reference Date	Completed On Date	Encoded By Date	Transmitted By Date
Discharge Assessment	7/16/02*	7/16/02 **	7/20/02	7/26/ 02	8/01/02

*This is either: (1) The day the patient is discharged from the IRF; or (2) the day the patient ceases receiving Medicare covered Part A fee-for-service inpatient rehabilitation services

** Except for some items, as discussed previously in section IV.A.3.of the final rule Preamble

Interrupted Stay

Chart 4- Applying the "Interrupted Stay" to the Assessment Schedule

Assessment Type	Observation Period	Interruption date	Return Date to the IRF
Admission	7/3, 7/4, 7/5	7/4/02	7/6/02

1- Interruption in stay occurred on 7/4/02

2- Interruption was for 3 days 7/4, 7/5, 7/6/02

3- Patient returned to the IRF on 7/6/02 prior to midnight

New Assessment Schedule is as follows:

Assessment Type	Hospitalization time period and Observation time period	Assessment Reference Date	Completion Date	Encoded Date	Transmission Date
Continuation of prior Assessment	7/6, 7/7 and 7/8	7/8/02	7/9/02	7/15/02	**

** If the patient is discharged on 7/16/02, the last permitted discharge patient assessment instrument encoding date is 7/26/02, and the admission and discharge data must be transmitted by 8/01/02. See Chart 3, which illustrates how to apply the patient assessment instrument discharge dates. Note that the span of time to complete the admission assessment is different from the time to complete the discharge assessment as discussed in this section IV.D of the final rule preamble.